DRAFT
11-30-2004

Proposed Rules
of
The Tennessee Department of Labor and Workforce Development
Division of Workers' Compensation

Chapter 0800-2-

In-Patient Hospital Fee Schedule

Presented herein are proposed rules of the Tennessee Department of Labor and Workforce Development submitted pursuant to T.C.A. Section 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Department of Labor and Workforce Development to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed rules are published. Such petition to be effective must be filed with the Workers' Compensation Division, Second Floor of the Andrew Johnson Tower located at 710 James Robertson Parkway, Nashville, TN 37243-0661 and in the Department of State, Eighth Floor, Tennessee Tower, William Snodgrass Building, 312 8th Avenue North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rules, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: E. Blaine Sprouse, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-0064.

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This In-patient Hospital Fee Schedule is applicable for all inpatient services as defined herein, and includes medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured workers under the Tennessee Workers' Compensation Act. This In-patient Hospital Fee Schedule is established pursuant to Tenn. Code Ann. 50-6-204 (Repl. 1999 and Public Chapter 962 (2004).

0800-2- __-.01 General Rules

(1) General Information

(a) Reimbursements shall be determined for services rendered in accordance with this fee schedule and shall be considered to be inclusive unless otherwise noted.

(b) Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual and customary charges or the maximum amount allowed under the Inpatient Fee Schedule.

(c) Inpatient hospitals shall be grouped into the following separate peer groupings:

Peer Group	1	Hospitals 1 - 299 Beds
Peer Group	2	Hospitals 300+ Beds
Peer Group	3	Rehabilitation Hospitals
Peer Group	4	Psychiatric Hospitals

(e) For each inpatient claim submitted, the provider shall assign a Medicare Diagnosis Related Group ("DRG") code which appropriately reflects the patient's primary cause of hospitalization.

(f) The inpatient hospital fee schedule shall become effective July 1, 2005 and shall be reviewed annually and may be updated annually.

(g) Ongoing analysis will be conducted as to the projected savings of this schedule, as well as any impact on patient services.

(h) Preauthorization is required for specific inpatient services.

0800-2-__-.02 Definitions

(1) "Administrator" means the chief administrative officer of the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.

(2) "Allowed Charges" means charges that have been reviewed and approved under an appropriate audit and utilization review as prescribed in the Division's Rules, or as determined by the Commissioner or the Commissioner's designee after consultation with the Medical Director.

(3) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development.

(4) "Division" means the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.

(5) DRG – Medicare classifications of diagnosis in which patients demonstrate similar resource consumption and length of stay patterns.

(6) In-patient Services - Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.

(7) Institutional Services - All non-physician services rendered within the institution by an agent of the institution.

(8) Length of Stay ("LOS") - Number of days of admission where patient appears on midnight census. Last day of stay shall count as an admission day if it is medically necessary for the patient to remain in the hospital beyond 12:00 noon.

(9) Medical Admission - Any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.

(10) Stop-Loss Payment ("SLP") - An independent method of payment for an unusually costly or lengthy stay.

(11) Stop-Loss Reimbursement Factor ("SLRF") - A factor established by the Division to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.

(12) Stop-Loss Threshold ("SLT") - Threshold of total charges established by the Division, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor times the total charges identifying that particular threshold.

(13) Surgical Admission - Any hospital admission where the primary services rendered are not medical, psychiatric or rehabilitative in nature.

(14) Transfers Between Facilities - To move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. May or may not involve a change in the admittance status of the patient, i.e. patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in facility in which patient has been admitted. Includes costs related to transportation of patient to obtain medical care [Medical Dispute Resolution definition derived from the definition provided for "transfer" in the Black's Law Dictionary, 5th Edition, ed. Henry Campbell Black, M.A. (St. Paul, MN: West Publishing Company, 1979)].

(15) Workers' Compensation Standard Per Diem Amount ("SPDA") - A standardized per diem amount established for the reimbursement of hospitals for services rendered.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 and Public Chapter 962 (2004).

0800-2- -.03 Special Ground Rules – Inpatient Hospital Services.

This section defines the reimbursement procedures and calculations for inpatient health care services by all hospitals.

(1) General Information

(a) For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (DRG) code which appropriately reflects the patient's primary cause for

hospitalization. Hospitals within each peer group shall be paid a maximum amount per inpatient day.

(b) The maximum per diem rate to be used in calculating the reimbursement rate is as follows:

Peer Group 1	$ 1,000.00	For Med./Surg.
Peer Group 2	1,500.00	For Med./Surg.
Peer Group 3	800.00	Rehabilitation Hospitals
Peer Group 4	700.00	Psychiatric Hospitals

Intensive Care/Critical Care Reimbursement rates:

Peer Group 1	$1,800.00
Peer Group 2	$2,500.00

All Trauma Care shall be reimbursed at $2,000.00 per day

(c) The In-patient Hospital Fee Schedule allows for independent reimbursement on a case-by-case basis if the particular care exceeds the Stop-Loss Threshold.

(2) Reimbursement Calculations

(a) Explanation

1. Each admission is assigned an appropriate DRG.

2. The applicable Standard Per Diem Amount (“SPDA”) is multiplied by the Length Of Stay (“LOS”) for that admission.

3. The Workers’ Compensation Reimbursement Amount (“WCRA”) is the total amount of reimbursement to be made for that particular admission.

(b) Formula

LOS X SPDA = WCRA

(c) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 2
MAX. Rate per Day: $1,500.00
Number Billed Days: 9
Billed Charges: $41,750

Maximum Allowable Payment: $13,500

(3) Stop-Loss Method

Stop-loss is an independent reimbursement factor established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.

(a) Explanation

1. To be eligible for stop loss payment, the total Allowed Charges for a hospital admission must exceed the hospital maximum payment, as determined by the hospital maximum payment rate per day, by at least $20,000.

2. This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.

3. Once the allowed charges reach the stop-loss threshold, reimbursement for all additional charges shall be made based on a stop-loss payment factor of 80%.

4. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

(b) Formula

(Additional Charges X SLRF) + Maximum Allowable Payment = WCRA

(c) Example

DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 2
MAX. Rate Per Day: $1,500
Number Billed Days: 9
Billed Charges: $41,750

Maximum Allowable Payment For
Normal DRG Stay $13,500

Versus: Billed Charges $41,750

Amount Payable Before Stop-Loss,
Lower of Charge vs. Maximum Allowable..... $13,500

Total Difference,
Charges vs. Payments $28,250

Difference Over & Above $20,000 Stop-Loss, $8,250
Payable at 80%..... $6,600

TOTAL PAYMENT
DUE HOSPITAL $20,100

(4) Billing For Inpatient Admissions

(a) All bills for inpatient institutional services should be submitted on the standard UB-82 (HCFA 1450) form or any revision to that form.

0800-2-____.04. Preauthorization.

(1) Procedures For Requesting Preauthorization

(a) The insurance carrier is liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subsection (g) of this section required to treat a compensable injury, when any of the following situations occur:

1. the treating doctor, his/her designated representative, or injured employee has received preauthorization from the carrier prior to the health care treatments or services; or

2. when ordered by the Division.

(b) The insurance carrier shall designate an accessible direct telephone number, and may also designate a facsimile number for use by the provider or the provider's designated representative or the injured employee to request preauthorization during normal business hours. The direct number shall be answered or the facsimile responded to, by the carrier's agent who is delegated to approve or deny requests for preauthorization, within the time limits established in subsection (d) of this section.

(c) Prior to the date of proposed treatment or services, the provider or the provider's designated representative, shall notify the insurance carrier's delegated agent, by telephone or transmission of a facsimile, of the recommended treatment or service listed in subsection (g) of this section. Notification shall include the medical information to substantiate the need for the treatment or service recommended. If requested to do so by the carrier, the treating doctor shall also notify the insurance carrier of the location and estimated date of the recommended treatment or service, and the name of the health care provider performing the treatment or service, if other than the provider. Designated representative includes, but is not limited to, office staff, hospitals, etc.

(d) Within three working days of the provider's request for preauthorization, the insurance carrier's delegated agent shall notify the provider or the provider's designated representative, by telephone or transmission of a facsimile, of the insurance carrier's decision to grant or deny preauthorization. When the insurance carrier approves preauthorization, the insurance carrier shall send written approval, or if denying preauthorization, shall send documentation identifying the reasons for denial. Notification shall be sent to the injured employee, the injured employee's representative if known, and the provider or the provider's designated representative, within 24 hours after notification of denial or approval.

(e) The insurance carrier must maintain accurate records to reflect information regarding the preauthorization request and approval/denial process.

(f) If a dispute arises over denial of preauthorization by the insurance carrier, the doctor or the injured employee may file a Request for Assistance with a Benefit Review Specialist.

(g) The health care treatments and services requiring preauthorization are: all nonemergency hospitalizations, and transfers between facilities.

0800-2- _____.05 Other Services

(1) Pharmacy Services

(a) Pharmaceutical services rendered as part of inpatient care are considered inclusive within the inpatient fee schedule and will not be reimbursed separately.

(b) All retail pharmaceutical services rendered will be reimbursed in accordance with the Pharmacy Schedule.

(2) Professional Services

(a) All non-institutional professional services will be reimbursed in accordance with the Tennessee Workers' Compensation Division's Medical Cost Containment Program Rules and the Medical Fee Schedule Rules.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).